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TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
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SUBJECT: **RECOMMENDATIONS FOR THE FUTURE OF KING/DREW MEDICAL CENTER**

This report to your Board provides an update on reforms at King/Drew Medical Center (KDMC) and specific recommendations regarding the future of KDMC. It responds to requests from your Board to answer the following questions:

1) What is the status of reforms to ensure patient safety and quality of care?
2) Should the County contract for care in the area served by KDMC?
3) What clinical services should be provided at KDMC or elsewhere in the community?
4) What are the Department of Health Services (DHS) recommendations for the future of KDMC?

Based on a careful review of available information, DHS finds that:

- Contracting out the operation of the hospital is not a viable short-term option.
- Data demonstrate early signs of improvement in many areas.
- A smaller clinical program consistent with the current and future needs of SPA 6 should be implemented.

Based on these findings, DHS believes that:

- The hospital must reform the clinical programs to do a limited set of specific services extremely well.
- This limited set of vital services must be those needed most by the residents of SPA 6.
- The focus of its recommendations should be on regaining accreditation and preserving funding for the hospital.

DHS therefore recommends that your Board:

1) Schedule Beilenson hearings necessary to revise the clinical footprint at KDMC through:
    a. Closure of inpatient Pediatrics, including the Neonatal and Pediatric Intensive Care Units.
    b. Closure of inpatient and outpatient Obstetrical (OB) services.
    c. Restructuring of surgical specialty and Anesthesia programs consistent with a non-trauma delivery model.
    d. Contracting for appropriate physician services.

2) Direct DHS to modify KDMC staffing and budget, without any increase in net County cost, to:
    a. Expand cancer screening, detection and treatment services.
    b. Expand services for diabetes, high cholesterol and high blood pressure.
    c. Expand outpatient general and specialty pediatric services.

3) Direct DHS to continue discussions with all interested parties to define the financial, operational and contractual parameters for contracting out the operation of KDMC.

4) Direct DHS to work with Navigant Consulting, Inc. (Navigant) to develop a transition plan.

5) Direct DHS, the Chief Administrative Office (CAO), and the Department of Human Resources (DHR) to develop a revised staffing model for the entire KDMC facility, similar in cost and structure to the staffing models at Olive View-UCLA and Harbor-UCLA Medical Centers.

DHS believes that these recommendations offer the best chance to restore accreditation to the hospital and retain State and federal funding.

STATUS OF REFORM

DHS and Navigant Consulting, Inc. (Navigant) Measures

Overall risk-adjusted death rates at KDMC between January 2002 and March 2005 do not differ from other teaching hospitals that belong to a national benchmarking program. The overall death rate at the facility has decreased over the past year. Attending physician documentation of care and of their supervision of resident physicians has also improved. Several core facility processes show signs of improvement, such as Emergency Department (ED) triage time, hospital average length of stay, ED length of stay, and average number of patients discharged by noon. Areas that need additional time and effort include nursing care and the hiring of permanent nursing staff, interdisciplinary aspects of care, reconstitution of middle management, medical staff function, and governance. A summary of available data on quality of care and patient safety was previously provided to your Board (see Attachment A).

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

The key areas that were out of compliance with the standards of JCAHO were: 1) governance; 2) quality of patient care; 3) competency of staff including physicians and residents; 4) staff orientation and education; 5) overall management and leadership; and 6) physical plant and environment. The progress on meeting those standards is:

1) Governance - A separate KDMC Hospital Advisory Board (KHAB) has been established. The fifteen members meet monthly, with subcommittees meeting more frequently. See more detailed discussion on Page 5.

2) Quality of Patient Care - There has been a reduction in unadjusted mortality. (See more detailed discussion in Attachment A.) There has been a new multidisciplinary Medication Task Force established to review and analyze medication errors and make recommendations on corrective actions. Patient throughput has been improved in the ED through the implementation of a more effective triage system, resulting in reduced triage times and more appropriate use of the Urgent Care Center. The key areas needing further improvement are the timely provision of some elements of inpatient care, nursing assessments, documentation and updating of care plans.

3) Competency of staff, including physicians and residents - Resident supervision has improved as detailed in Attachment A. Little progress has been made in reducing the use of contract nursing staff. The percentage of nursing registry staff has increased with the removal of poorly performing KDMC staff. Recruitment continues to be a struggle in our goal to develop a permanent, stable, engaged, and high performing workforce. Navigant has implemented a program to improve the medical staff peer review process.

4) Orientation and education - Key efforts underway include improvement of medication administration, patient assessment, event reporting, management of abusive behavior, cardiac monitoring, and infection control. Staff training has been conducted in didactic sessions, hands-on demonstrations, and drills. Active monitoring has been implemented through the use of Clinical Assessment Teams composed of physicians and nurses who engage in active trouble-shooting, direct observation, and random spot checks. Significant additional training is still needed. The pace of training has been moderated by how much the staff can absorb in the time period.

5) Management and leadership - Executive staff and mid-level manager recruitment efforts continue. Interdisciplinary management meetings are now held weekly with interim and permanent managers. Management training and development has been launched now that permanent managers are being hired and beginning work. Clear lines of reporting responsibility and measurable performance expectations for management and staff have been established. Communication with staff has improved through the monthly publication of an employee newsletter, regular employee forums, and the establishment of Executive Patient Safety Rounds.

6) Physical plant and equipment - The building is not fully in compliance with physical plant requirements. A listing of needed facility and equipment improvements has been compiled. Many basic repairs have been made. For major projects, plans have been developed and funding is being sought.

In order to more accurately assess readiness and focus preparations for a re-survey, a mock JCAHO survey is scheduled for August 8-10, 2005. This initial mock survey will help identify areas where compliance with standards can be identified, as well as areas in need of further improvement. Subsequent mock surveys will be planned.

Centers for Medicare and Medicaid Services (CMS)

During an October 2004 survey (the results of which were formally provided to KDMC in April 2005), CMS cited KDMC for non-compliance with 40 unique requirements. In response to these survey findings, a plan of correction has been developed. This plan identifies the actions that will be taken to resolve deficiencies on a permanent basis, and assigns accountable executive and management leads. Performance measures for each corrective action have been defined and are being collected and reported to monitor progress and ensure compliance with these CMS requirements.

Most of the CMS requirements are related to: 1) medical staff organization and accountability; 2) patient rights; 3) staffing and delivery of care; and 4) preparation and administration of drugs.

The deficiencies regarding patient rights were related to the use of patient restraints. Efforts to improve throughput in the Psychiatric ED continues. In an effort to meet the significant demand for psychiatric services in the community, KDMC leadership is also working with the CAO to secure funding to finish remodeling the existing Psychiatric Unit. Corrective action plans have been submitted and accepted for these deficiencies.

In addition, the quality improvement program has been restructured, including the establishment of a Hospital Quality Committee that reports to the Quality Committee of the KHAB. A full-time Navigant Director for Quality is in place and works closely with the Navigant Associate Medical Director to review all incidents and determine appropriate follow-up. Patient Safety and Quality performance measures have been identified and a process is in place to measure and track outcomes. A multidisciplinary Medication Event Task Force has been established and meets weekly to review medication events, identify and implement corrective actions, and follow up to ensure continued compliance. A full-time Director of Pharmacy has been recruited and hired. Competency testing has been successfully completed for all pharmacists and is underway for the technicians. The Infection Control program was redesigned and policies and procedures are being revised to reflect current industry standards. For each of these areas, performance measures have been identified and are being tracked to monitor outcomes.

Navigant's Plan

Navigant outlined 1,052 recommendations for improvement in their January 31, 2005 report. DHS along with the KHAB has monitored these efforts. The recommendations were categorized into urgent, short-term, intermediate, and long-term, with targeted completion dates.

In its June 24, 2005 report, Navigant reported that overall 36 percent of the recommendations were completed, while by category 94 percent of the urgent, 41 percent of the short-term, eight percent of the intermediate, and five percent of the long-term recommendations were completed. DHS and the Auditor-Controller's Office performed an independent audit of a select group of urgent and short-term recommendations. DHS identified a full compliance rate of 68 percent and additional 30 percent of partial compliance for the recommendations reviewed in the audit. Navigant's major challenge in achieving full compliance was demonstrating that changes in policies, procedures and processes had been fully implemented at all times in the front-line delivery of care.

Hospital Advisory Board

On February 8, 2005, the Board of Supervisors established the KHAB, and in subsequent meetings appointed 15 KHAB members. The KHAB has conducted four monthly open meetings, and has formed standing Committees on Quality and Planning & Finance. An ad hoc Steering Committee, composed of several KHAB members and members of the KDMC administrative team, has been meeting weekly to discuss current operational issues and to provide additional guidance to Navigant and DHS on their reform efforts.

Human Resource Actions

The Department of Human Resources (DHR) reported on July 29, 2005 that it has taken disciplinary actions against 250 KDMC employees since January 2004. Of these, 129 actions have resulted in discharges or resignations. DHR continues to investigate disciplinary matters as they are reported.

Status of Recruitments

The following is a status of the recruitment efforts for key executive and leadership positions at KDMC:

Position	Candidate
Chief Executive Officer (CEO)	A candidate has been offered the position and negotiations are in progress; expected completion 8/10/05.
Chief Operations Officer (COO)	Eligible list is available for use by CEO once appointed.
Chief Nursing Officer (CNO)	A candidate has been offered the position.
Pharmacy Services Chief, III	Completed. John Sang began work on 7/11/05.
Director, Hubert H. Humphrey Comprehensive Health Center	Candidate has accepted position. Anticipated start date 8/8/05, pending background check and pre-employment physical.
Clinical Nursing Director II, Perioperative/Women's Health	Candidate has accepted position. Anticipated start date in mid-August, pending CAO approval, Board notification, background check, and pre-employment physical.
Clinical Nursing Director II, Medical/Surgical	Completed. Constance Doyle started 7/18/05.

DHS and Navigant continue to work with DHR to recruit aggressively for other critical physician, nursing and administrative positions.

HEALTHCARE DELIVERY NEEDS OF SERVICE PLANNING AREA (SPA) 6

Community Profile

KDMC patients chiefly reside in the South Service Planning Area (SPA 6). The community around KDMC is younger, poorer, and less likely to have health insurance than Los Angeles County as a whole. SPA 6 has the County's highest rates of teen pregnancy and low weight births. Obesity is common, contributing to mortality rates from cardiovascular disease and diabetes that are higher than the County average. Cancer mortality is particularly high in SPA 6, with a rate nearly 30 percent higher than the overall County rate. One in four adult residents of SPA 6 has been diagnosed with high blood pressure, and one in ten has been diagnosed with diabetes. While the mortality rate from diabetes remains comparatively low, it has shown an alarming increase over the past decade.

DHS conducted planning meetings with KDMC staff, Drew University officials, and community stakeholders regarding service needs. The results of these meetings led to a prioritization of programs that would best serve the community surrounding KDMC and the current users of the facility. The programs identified as most needed are:

- Cardiovascular disease diagnosis and treatment
- Diabetes prevention, diagnosis and care programs
- Cancer prevention, diagnosis and treatment
- Mental health and substance abuse treatment
- Asthma prevention, diagnosis and care programs

A more detailed discussion of DHS' Community Needs Assessment for SPA 6 is presented in Attachment B of this document.

Patient Care Trends

Births in DHS facilities have declined every year since 1990, as private sector facilities have aggressively marketed their OB services to Medi-Cal patients. Health insurance coverage of children has also significantly improved over the last several years through the Healthy Families program, First Five LA's Healthy Kids program and the Children's Health Initiative. As a result, all DHS hospitals have seen a falloff in the number of pediatric admissions.

Role of KDMC in Meeting the Care Needs of SPA 6

The data are clear:

- Pregnant women who obtain insurance increasingly choose non-DHS facilities.
- Parents increasingly take children with insurance to non-DHS facilities.
- Hospitals with OB programs typically deliver at least 1,000 babies per year.
- Private hospitals in Los Angeles County with OB services delivering fewer than 1,500 births annually do not operate NICUs; instead, all babies needing NICU care are transferred to other facilities.
- When children are sick enough to require hospitalization, they should be hospitalized in a facility with sufficient volume in pediatrics.

We therefore undertook the design of a care delivery model at KDMC that would serve two purposes: 1) target the highest needs of the SPA 6 population while recognizing utilization trends and patient choice; and 2) further concentrate the administrative and clinical resources of KDMC so that they can be focused on problem-solving until accreditation is regained and staffing is improved.

RECOMMENDED CARE DELIVERY MODEL

Given the high level of need and relative scarcity of healthcare resources in SPA 6, DHS a model in which no healthcare services are provided on the current KDMC site was not considered a viable option at this time. Therefore only three models of care delivery for the KDMC service area were considered: 1) a multi-service ambulatory care center (MACC) operated by DHS on the current site, with inpatient services provided by other DHS facilities or purchased from private hospitals in the area; 2) a contracted-out hospital with a DHS-operated MACC; and 3) an Academic Community Hospital operated by DHS on the current site. Pros and cons along with a proposed clinical service footprint for each model were evaluated.

Model 1 – MACC Only

KDMC would be closed. In addition to using some capacity at other DHS hospitals, the County would purchase beds from private facilities and open a MACC that would be operated by DHS. While DHS could easily accommodate the OB and pediatric services currently being provided at KDMC within the DHS system, providing for approximately 150 to 160 beds in other DHS hospitals would not be feasible in the short term and if achieved in the long term would result in patients having to travel greater distances to receive inpatient care at DHS facilities, or else use local non-DHS facilities. A survey of private hospitals in the vicinity of KDMC found that presently there are no more than 50 private adult medical/surgical beds available, and these beds would not be available during the winter flu season when hospitalizations increase. These local private hospitals might be able to provide between 80 and 100 additional beds to the community in the future but this would involve remodeling of closed wards as well as relicensing of beds currently used for skilled nursing or other lower levels of care. These conversions would take many months. These beds would also require County funding.

Conclusion: Model 1 is not feasible because it would require a protracted period of time to implement and a large County-funded purchase of private sector beds.

Model 2 – Hospital operations contracted out, with DHS-operated MACC

In this model, a privately operated hospital on the grounds of KDMC would be supplemented with a DHS-operated MACC. This model could have merit in the future but is not viable now. While there are no legal reasons that preclude the County from pursuing this option, there are numerous operational, legal, financial, and logistical issues and requirements that make implementation extremely complicated. Of significant note is the uncertainty regarding the specifics of Medi-Cal Redesign, which will inevitably dictate some of the financial and legal underpinnings of any contract with a private provider. According to the analysis done by Shattuck Hammond, agreement on a plan for contracting out the operations at KDMC could not be accomplished in less than six to twelve months.

Once completed, another six to twelve months would be required to complete the conversion to a private entity.
Conclusion: Model 2 is not feasible in the short-term because it realistically will require a timeframe of eighteen months to two years to implement. However, the County should continue to actively explore this option.

A detailed analysis of Models 1 and 2 can be found in appendix C.

Model 3 – Academic Community Hospital

DHS believes that a smaller, more focused hospital with expanded outpatient programs will best serve the needs of the SPA 6 population and will concentrate and focus the administrative and clinical resources of KDMC, allowing the maximum chance for timely restoration of accreditation and full adherence to Medicare's conditions of participation. Operation of a smaller hospital addresses the most significant needs of the community while at the same time offering the only alternative for reform that can be fully implemented by the beginning of the next fiscal year. This model also best prepares the facility should the decision be made to contract out hospital operations.

Model 3 also offers the least disruption in services. The current hospital license would remain in effect and most of the current staff would remain at the hospital. This model would target an average daily inpatient census of about 154, which is 20 less than the Fiscal Year (FY) 2004/2005 average. The number of outpatient visits would increase by about 2,250.

Clinical Program Changes

Under Model 3, DHS proposes the following changes to the current clinical programs:

1) *Closure of OB and Inpatient Pediatrics*:
The needs assessment in Attachment B clearly demonstrates that, while SPA 6 may have a large number of children and women of child-bearing age, KDMC is not a significant provider of either pediatric or OB services. These patients receive their care almost entirely in the private sector. Harbor-UCLA and LAC+USC Medical Centers can readily absorb the pediatric and OB patients currently seen at KDMC if these patients elect to seek care in the County system.

2) *Restructuring of Surgical Services Consistent with a Non-Trauma Hospital*:
Given the importance of regaining full approvals from JCAHO and CMS and given the successful transition of trauma patients to surrounding facilities, trauma services should remain closed for at least the next several years. The surgical, anesthesiology and operating room staffing should be adjusted to fit a non-trauma model. This includes major reductions in neurosurgery and cardiothoracic surgery personnel, and smaller reductions in general surgery and many of the other surgical subspecialties.

3) *Contracting for Radiology, Anesthesia, ICU and ED Physician Services:*
For these clinical services, it is difficult to recruit qualified physicians to provide comprehensive coverage around the clock. Several local and national physician staffing companies have expressed interest and would be able to provide comprehensive services in these specialty areas. Several companies can provide all four of the services. DHS recommends that a Request for Proposal be issued to obtain further information from these groups. If financially and operationally feasible, DHS will recommend to your Board that we enter into outside contracts for these services.

4) *Expansion of Outpatient Services in Cancer, Diabetes, High Cholesterol, and High Blood Pressure*:
High rates of cardiovascular disease and diabetes in the community indicate that outpatient care should be expanded in these areas, including screening and treatment for high blood pressure and high cholesterol. As a significant provider of cancer care to the uninsured population in SPA 6, DHS should expand these services with the goals of prevention, early diagnosis and definitive treatment.

5) Expansion of Outpatient Pediatrics Services:
Pediatric outpatient care should be continued and expanded, and services should be integrated with the newly opened Women's Center. This new emphasis on family health would allow a comprehensive and preventative approach to maternal and child health and family planning. Routine pediatric admissions (e.g., for asthma, dehydration, or antibiotic therapy) would be absorbed by neighboring hospitals while those requiring specialty services would be referred to facilities with a pediatric specialty focus.

Revised Staffing Model

Based on all available data, DHS believes that certain services at KDMC can be safely provided with fewer staff. This will result in more dollars available to provide needed services to the community. Revisions will be guided by review of staffing models at Olive View-UCLA and Harbor-UCLA Medical Centers.

Financial Impact

Implementation of this model, not including potential savings due to contracting out physicians or the implementation of a revised staffing model, and notwithstanding Medi-Cal Redesign, would reduce costs by approximately $29.8 million, and revenue by approximately $26.1 million, for a net savings of about $3.7 million.

Medi-Cal revenues under Medi-Cal Redesign remain uncertain for Fiscal Years 05-06 and forward. In prior years, these revenues included inpatient fee-for-service, SB1255, and Disproportionate Share Hospital (DSH) funds, which amount to about $120 million

in KDMC's current-year budget. These revenue streams will be reformed under Medi-Cal Redesign. The State's proposal is to delegate the distribution of the reformed funds to the California Medical Assistance Commission, which would likely result in a lengthy and uncertain process, leaving the amount of such funds for each impacted hospital, including KDMC, unspecified for many months. However, the State has indicated that it is receptive to looking at alternative approaches and, accordingly, the California Hospital Association DSH Task Force, of which the County is a member, is currently reviewing formula-based approaches, which would provide greater certainty much sooner. The State is pursuing the enactment of legislation encompassing Medi-Cal Redesign distribution methodology by the September 9, 2005 Legislative recess.

Human Resources Impact and Timelines

Implementation of this model will result in the elimination of approximately 210 to 260 positions from KDMC, depending on the extent to which physician services are contracted out. Revisions to the staffing model will add significantly to the number of positions eliminated. While the majority of staff impacted by these reductions could be reassigned to existing vacancies throughout DHS, a workforce reduction may be necessary for displaced employees where internal department placement cannot be accommodated in accordance with Civil Service rules. The timeline to complete the process is approximately six months, which includes time for mandatory Beilenson Hearings and union notifications.

Academic Affiliation

With the proposed restructuring of the clinical program at KDMC, the presence of residency training, the number of training programs and the appropriate academic partner(s) must be addressed.

In this model, DHS recommends the continuation of limited residency training activities. On balance, residency programs generally improve a hospital's ability to efficiently treat and discharge patients, and are a useful source of manpower. Residency training programs are important tools for recruiting attending physicians to work at the hospital. This is a critical differentiating tool in our efforts to recruit high quality physicians into our system where salary and other "perks" are generally not at the top of market.

The most important consideration in model development was the current and future clinical needs of SPA 6. The decision about academic affiliation is an important, but secondary, consideration.

An initial question is whether to provide this training under the current structure with Drew University. As described in the August 3, 2005 DHS memorandum to your Board, Drew University has made very substantial progress in addressing areas of concern and meeting the minimum requirements the County imposed. If Drew continues to make

progress, then DHS will recommend to your Board in September that the affiliation agreement be extended for one year. Critical to this extension will be an implementable transition plan for reshaping the residency programs as well as a fully described Institutional Review planning process.

The discontinuation of OB services and inpatient pediatrics at KDMC will require Drew to decide whether to continue the OB and Pediatrics residency programs using rotations to other hospitals, or to discontinue the programs. If either program is discontinued, Drew should notify ACGME and the National Resident Match Program (NRMP) by January 31, 2006 to prevent OB and Pediatrics residency applicants from interviewing at KDMC prior to the match for the academic year 2006-2007. Current residents must be notified of changes in the number of residency positions by November 15, 2005, pursuant to the memorandum of understanding with the Joint Council of Interns and Residents. Moreover, DHS has an obligation to help place the existing residents if a program is downsized or discontinued.

The Pediatrics residency at KDMC is a three-year training program. A total of 24 pediatric residents currently training at KDMC are expected to graduate in years 2007 and 2008 and would be affected.

The Obstetrics and Gynecology residency at KDMC is a four-year program. If this program is discontinued, a total of ten current residents who are scheduled to graduate in 2006, 2007, and 2008 would require placement services.

As outlined in DHS' May 6, 2005 report to your Board, recommendations relating to training programs at KDMC included the following options:

- Operating a non-teaching facility;
- Establishing a model similar to that at Olive View-UCLA Medical Center in which KDMC acts as a rotation site for UCLA residents;
- Direct sponsorship and operation of a training program by DHS without an academic partner; or
- DHS sponsorship and operation of a training program with another academic partner, such as UCLA, the University of Southern California, or other appropriate entity

Transferring training program sponsorship to the County would be a lengthy process requiring up to a year to complete and would be difficult in light of KDMC's JCAHO status.

Restructuring the training programs so that they are similar to those at Olive View-UCLA Medical Center, with Drew University and other academic affiliates is the best option.

Whether under the present relationship with Drew University or some other structure, DHS believes that a far more limited mix of residencies is appropriate for KDMC going forward. Core programs such as Internal Medicine and Psychiatry need to be continued. General Surgery, a key program that was lost, should be rebuilt. However, many of the smaller surgical and medical fellowships should be considered for merger with other academic programs or eliminated entirely to help KDMC and its academic partner(s) focus on the hospital's core clinical mission. Some programs should be phased out entirely; while others should not be considered for rebuilding, such as Radiology.

Pros and Cons of Model 3

Advantages of this model include: minimal disruption in services compared to the other models; can be implemented within the fiscal year; focus on core areas will allow the consolidation of resources and facilitate improvement in quality of care and patient safety; this model will have the smallest impact on human resources, with most current KDMC employees remaining at the facility; and the financial impact will be minimized.

Disadvantages include: ongoing difficulties with recruitment due to healthcare worker shortages and public perceptions of the hospital, and ongoing need to assess and improve the skills and judgment of existing personnel.

How this Model Differs from the Current Situation:

KDMC will concentrate its management and resources on fewer inpatient clinical programs and would require fewer inpatient clinical personnel. Rarely used, high-level specialty services will be concentrated at either LAC+USC or Harbor-UCLA Medical Centers. This regionalization of services is consistent with strategies employed in private sector health systems.

DHS is in final negotiations to hire an experienced hospital executive to oversee our facility CEOs. DHS also anticipates hiring a new CEO for KDMC within the next week. In addition, several key leadership positions have been filled, as noted above. These appointments will allow permanent leaders to take over the operations of the hospital from Navigant by the expiration of its contract and should improve KDMC's ability to recruit other staff. DHS is working to secure the services of additional mid-level nurse managers who will focus on assessment, education and mentoring of nursing staff.

KDMC will operate several services in a pure service, non-academic mode. Where available and appropriate, physician services will be purchased on a per-hour or per-service unit basis.

Additional options if KDMC is not successful in restoring JCAHO or meeting Medicare's Conditions of Participation:

DHS also recommends that the County engage in discussions with all interested parties regarding contracting out the operations at KDMC and continue to define the operational and legal parameters for such a contract. While these discussions may not result in a contract if the KDMC turnaround is successful, the effort involved in such discussions is small in comparison to the value of being able to rapidly move to a contracted model should it become necessary. However, an abrupt withdrawal of licensure could result in a period of closure until negotiations could be finalized.

RECOMMENDATIONS FOR IMPLEMENTATION OF MODEL 3

The Department recommends that your Board:

1) Schedule the Beilenson Hearings necessary to revise the clinical footprint for KDMC through:
   a. Closure of inpatient Pediatrics, including the Neonatal and Pediatric Intensive Care Units.
   b. Closure of inpatient and outpatient OB services.
   c. Reducing and restructuring of surgical specialty and Anesthesia programs consistent with a non-trauma delivery model.
   d. Contracting for appropriate physician services.

2) Direct the Department to modify KDMC staffing and budget, without any increase in net County cost, to address the community's needs by:
   a. Expanding cancer screening, detection and treatment services.
   b. Expanding services for diabetes, high cholesterol and high blood pressure.
   c. Expanding outpatient general and specialty pediatric services.

3) Direct DHS to continue discussion with all interested parties to define the financial, operational and contractual parameters for contracting out hospital operations at KDMC.

4) Direct DHS to work with Navigant to develop a transition plan.

5) Direct DHS, CAO, and DHR to develop a revised staffing model for the entire KDMC facility, similar in cost and structure to the staffing models at Olive View-UCLA and Harbor-UCLA Medical Centers.

Attachment E provides a list of the major action steps needed and timeline for full implementation of the model by June 30, 2006, the end of the academic and County fiscal years.

If you have any questions or need additional information, please let me know.

TLG:BC:id

Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT A

QUALITY OF CARE AND PATIENT SAFETY AT KDMC

Overview

KDMC has had a long history of clinical and administrative challenges. In the last year, DHS has undertaken a series of initiatives in an effort to fundamentally change the course of the facility. These initiatives include:

- A nursing review by the Camden Group resulting in the removal of the majority of the senior nursing management team (December 2003 to November 2004).
- Reassignment of senior managers from within DHS to take over operations of the hospital and medical directors' office (October 2003 to November 2004).
- The closure of the Trauma Center to decompress the ED and to reduce the severity of illness burden in the facility (March 1, 2005).
- The introduction of the Navigant Group to fill all key executive and senior management positions on an interim basis, to assess and improve all facets of the clinical program as well as redevelop management processes (November 2004 to present).

Is the Hospital Safe?

All hospitals are risky environments. National efforts to address risk and improve outcomes have been well documented by a variety of organizations such as the Institute of Medicine's Crossing the Quality Chasm and To Err is Human reports. While individual cases have raised concerns and highlighted specific areas that need improvement, data sets that compare KDMC to other hospitals demonstrate mortality rates that are comparable to similar types of hospitals. DHS participates in a national hospital data-benchmarking program for quality improvement purposes. When compared with other academic and public medical centers based on the data submitted by these organizations:

- The overall risk-adjusted mortality rate is not significantly different at KDMC than the national average.
- The overall risk adjusted mortality rate is not significantly different between DHS facilities.
- Post-procedure mortality rates for the first quarter of 2005 and running year (April 2004 to March 2005) met national performance targets.
- In-hospital mortality for specific common medical conditions (i.e., pneumonia, strokes, heart attacks, heart failure, gastrointestinal bleeding, and hip fractures):
    - Met national performance targets for five of six common medical conditions in the first quarter of 2005

- Met national performance targets in six of six common medical conditions and exceeded national performance on one of these six conditions for running year April 2004 to March 2005.

The closure of the Trauma Center was a specific attempt to decrease the acuity of patients in the facility and to decompress the ED in an effort to improve the safety margin of the facility. The expected outcome was a decrease in the overall mortality rate of the facility as the acuity decreased. This is exactly what has occurred.

- The monthly number of inpatient deaths (unadjusted for acuity) has decreased from 26 in January 2005 to 15 in June 2005.
- The total monthly unadjusted number of deaths (including patients arriving at the hospital already dead and those dying in the ED) has decreased from 60 in January 2005 to 36 in June 2005.
- If we compare the number of deaths to the number of admissions, the unadjusted mortality rate goes from 3.2 percent in January to 1.6 percent in June.
- All these rates reflect dramatic reductions after March 2005 when Trauma was closed.

Have There Been Measurable Improvements Over the Past Year?

Organizational improvement is measured across two domains – process and outcomes. When working through system change process improvements generally are the leading indicators of improvement while outcomes tend to be lagging indicators. It is critical to note that when Navigant arrived data collection was extremely uneven and use of data to manage functions was also extremely poor. As Navigant implemented appropriate data collection and management activities, some metrics appeared to get worse initially. This is a direct result of prior incomplete data collection and under-reporting and not necessarily a reflection of a change in clinical care. A wide variety of measures are tracked on a daily, weekly and monthly basis. Most of this data is formative as opposed to definitive. Data samples may be small in a given a week so what is important are the trends within the data as opposed to the absolute result.

<u>Monthly trend improvements include:</u>

- A significant decrease in ED average triage time from 75 minutes in January 2005 to 35 minutes in May 2005.

- A significant and continuous decrease in the number of falls in hospitalized patients from ten in January 2005 to two in May 2005. Fall rate is a proxy measure for the effectiveness of physician and nursing care planning and the attentiveness of bedside nursing care.

- Average hospital length of stay improved from 5.5 days in January 2005 to 4.4 in May 2005. The length of stay is also a proxy measure for organizational effectiveness.

- Ventilator associated infections in ICU A decreased from 9.5 per 1,000 ventilator days in January 2005 to 4.2 per 1,000 days in May 2005 and from 18 in January 2005 to 12.6 infections per 1,000 days in June 2005 in the CCU. This is a national indicator, related to the effectiveness of clinical management for these high-risk patients.

- The average length of stay in the ED for patients who are admitted decreased from 17 hours in January 2005 to 9.8 hours in June 2005, and the length of stay for patients who are treated and released decreased from 15 hours in January 2005 to 8.0 hours June 2005. This is also a measure of improvements in organizational efficiency.

- The average total triage time in the ED has decreased from 189 minutes in January 2005 to 95 minutes in June 2005.

- Compliance with ACLS protocol response was 100 percent in May and June 2005.

- Average percent of patients discharged by noon increased from 3 percent to 8 percent.

Weekly trend improvements include:

- Implementation of a Code 9 policy (for management of assaultive behavior) with monthly tracking demonstrating 100 percent compliance.

- Comprehensive restructuring of the physician on-call scheduling process with continuous improvement of both system and individual issues.

- Implementation of an ED diversion policy that appropriately moves the ED to diversion status when the ED exceeds defined census targets.

DHS Performance Indicators:

DHS has been collecting performance indicators across DHS for several years. A subset of this data is presented here:

- Availability of electronic discharge summaries within 30 days has improved from 0 percent in 2003 to approximately 50 percent by the end of 2004.

- Measures related to management of heart attacks have remained stable using a 12-month running average from October 2003 to December 2004; however, KDMC's performance relative to other DHS facilities is lower. For instance, compliance with administration of specific medications within 24 hours is 71 percent while other DHS facilities range from 91 percent to 98 percent; and compliance with administration of aspirin on arrival is 88 percent at KDMC while other DHS facilities compliance is 95 percent to 99 percent.

- Measures related to management of pneumonia have remained stable over a 12-month running average from October 2003 to December 2004; however, KDMC's performance relative to some other DHS facilities is lower. For example, in measures related to providing advice for smoking cessation, KDMC's compliance is 11 percent while other DHS facilities range from 8 percent to 63 percent. However, the more clinically pertinent indicator of oxygenation assessment shows KDMC's compliance at 94 percent, while other DHS facilities range from 79 percent to 100 percent.

- Measures related to the management of congestive heart failure have decreased slightly over a 12-month running average from October 2003 to December 2004. As an example, compliance with complete discharge instructions is 16 percent (down from 19 percent), while other DHS facilities range from 28 percent to 56 percent. In another example, the measure that addresses administration of specific medications at discharge has shown a slight downward trend over the last 2 years; however, the measure's compliance is high at 90 percent, with other DHS facilities ranging from 73 percent to 92 percent.

Evidence of Improved Residency Supervision:

The DHS Quality Improvement Program (DHSQIP) conducts periodic audits of Resident Supervision. In 2003 DHSQIP conducted an audit of over 200 medical records looking for documentation that an attending physician was overseeing the care. Data on three of the high volume indicators reveal improvements in resident supervision.

- In 2003 documentation of supervision for patient admissions to a general nursing ward was 74 percent in a sample size of 290 records. In 2004, a larger sample of 340 records showed compliance at 85 percent. A repeat spot audit in 2005 with a smaller sample of 20 open records (10 percent of inpatient records) demonstrated 100 percent compliance.

- In 2003 documentation of daily oversight for general ward inpatients demonstrated 51 percent compliance in a sample size of 258 records. In 2004, with a sample size of 290 records, compliance improved to 64 percent. In the recent spot audit of 2005 with a sample of 18 open records, compliance was 94.5 percent.

- In 2003 documentation of attending supervision in the ED reflected a compliance rate of 80 percent with a sample size of 220. In 2004, compliance was 97 percent with a sample size of 609. In the recent spot audit of 2005, compliance was 86.5 percent with a sample size of 89 records.

These leading indicators suggest that critical management, direct patient care and cultural changes are beginning to take hold. There are still many areas where improvements have yet to fully take hold. These are areas that are currently under extraordinary focus by Navigant. Many of the open issues involve interdisciplinary care delivery such as the operating room and medication management. Oversight of line nursing functions also remains an important issue, but DHS and Navigant have made headway in hiring clinical nursing directors to help address this issue over the longer term.

Metrics where significant improvements have not been documented include:

- Operating Room suite utilization has remained relatively stable at 26 percent in January 2005 and 25 percent in May 2005.
- Nursing assessment documentation completed within 24 hours has gone from 95 percent in January 2005 to 86 percent in May 2005. A similar measure in the ED ranges from 90 percent to 54 percent during the 5-month period of January 2005 to May 2005.
- Completion of vital signs was cited by various regulatory agencies. In the ED the percentage of completing vital signs every two hours ranges from 76 percent to 96 percent over the 5-month period of January 2005 to May 2005. Similarly, on the nursing units the compliance ranges from 85 percent to 93 percent between January 2005 and June 2005.
- Documentation of physician notification of abnormal vital signs has decreased from 75 percent in January 2005 to 58 percent in May 2005.

During this period of time (January 2005 to June 2005) the nursing turnover rate has fluctuated between 20 percent and 21.9 percent, with June 2005 data reflecting a net loss of seven registered nurses. The percent of traveler nursing staff to total productive nursing hours is between 53 percent and 62 percent depending on the nursing unit. This lack of continuity in the nursing workforce will slow progress along these indicators.

Overall, the data suggests that improvements have been made in some areas of operational efficiency and clinical competence and resident supervision. However, there is still a need to generalize and institutionalize these improvements across the organization. Further, these data represent only a short period of time, and as processes improve it will be important to move toward gathering more outcome data.

ASSESSMENT OF COMMUNITY NEED

The recommendations in this document are based on a comprehensive analysis of what health services are needed by the community residing in the KDMC area. The historical significance of KDMC's role in the community is best honored by prioritizing the community's current and emerging healthcare needs. DHS must move to address areas with the greatest unmet need, taking other providers and resources into consideration, adjust its clinical program in response to changing patterns of utilization, and continue to improve its collaboration with other healthcare resources in the community.

The majority of patients using KDMC reside in the South Service Planning Area (SPA 6). Table 1 shows that the community around KDMC is younger, poorer, and less likely to have health insurance than Los Angeles County as a whole. There continues to be a significant African-American presence in SPA 6, although the area has become predominantly Latino. These two groups suffer from overall health disparities as well as specific health problems that differ from the general population.

Table 1: Demographics of South Service Planning Area (SPA 6)

Demographic Indicator	SPA 6	Los Angeles County
Residents below 100% of Federal Poverty Level	31%	18%
Residents below 200% of Federal Poverty Level	61%	40%
Latino residents	60%	45%
African American residents	35%	9%
Residents under 25 years of age	48%	38%
Uninsured adults (ages 18-64)*	36%	26%
Uninsured children*	18%	10%

SOURCES: U.S. Census Bureau, Census 2000. Summary, SPA-level, and FPL statistics compiled by United Way of Greater Los Angeles.
* LADHS Office of Health Assessment and Epidemiology, Health Assessment Unit, 2002-2003 Los Angeles County Health Survey.

The community has more general health-related issues stemming from lack of access to the basic elements of a healthy lifestyle. As shown in Table 2 (next page), SPA 6 features fewer parks and playgrounds, higher homicide rates, and less access to healthy food than any other SPA in the County. SPA 6 has the highest rate of teen pregnancy in the County. Expectant mothers in SPA 6 are the least likely to receive prenatal care, and their babies are the most likely to be born at a low birthweight.

Table 2: Key Health Indicators for South Service Planning Area (SPA 6), 2002/2003[a]

Health Indicator	SPA 6	Los Angeles County
Parks or playgrounds not easily available[b]	28%	17%
Public high school dropout rate[c]	27.4	14.8
Homicide rate among ages 15-34 (age adjusted per 100,000 population)[d]	78.6	25.6
Fruit and vegetable consumption under 5/day among adults[b]	91%	88%
Obesity among adults[b]	30%	19%
Overweight children in grades 5,7, and 9[e]	26%	21%
Teen (ages 15-19) birth rate per 1,000[f]	85.7	44.4
Mothers receiving late or no prenatal care[f]	19%	14%
Low birthweight (<2,500 gram) births[f]	7.3%	6.7%

a SPA 6 indicators are statistically different from indicators for Los Angeles County as a whole ($p<0.05$).
b SOURCE: LADHS Office of Health Assessment and Epidemiology, Health Assessment Unit, 2002-2003 Los Angeles County Health Survey.
c SOURCE: California Department of Education.
d SOURCE: LADHS Office of Health Assessment and Epidemiology, Data Collection and Analysis Unit.
e SOURCE: Prepared by LADHS Office of Health Assessment and Epidemiology from data obtained from the 2002 California Physical Fitness Testing Program, California Department of Education.
f SOURCE: LADHS Maternal, Child and Adolescent Health Program. 2001 data.

Overweight and obesity are epidemic, contributing to the mortality rates from cardiovascular disease and diabetes that are higher than Los Angeles County's average. Cancer mortality is particularly high in SPA 6, with a rate nearly 30 percent higher than the overall County rate. Table 3 compares mortality rates as well as the prevalence of high blood pressure and diabetes diagnoses in SPA 6 with the corresponding countywide figures.

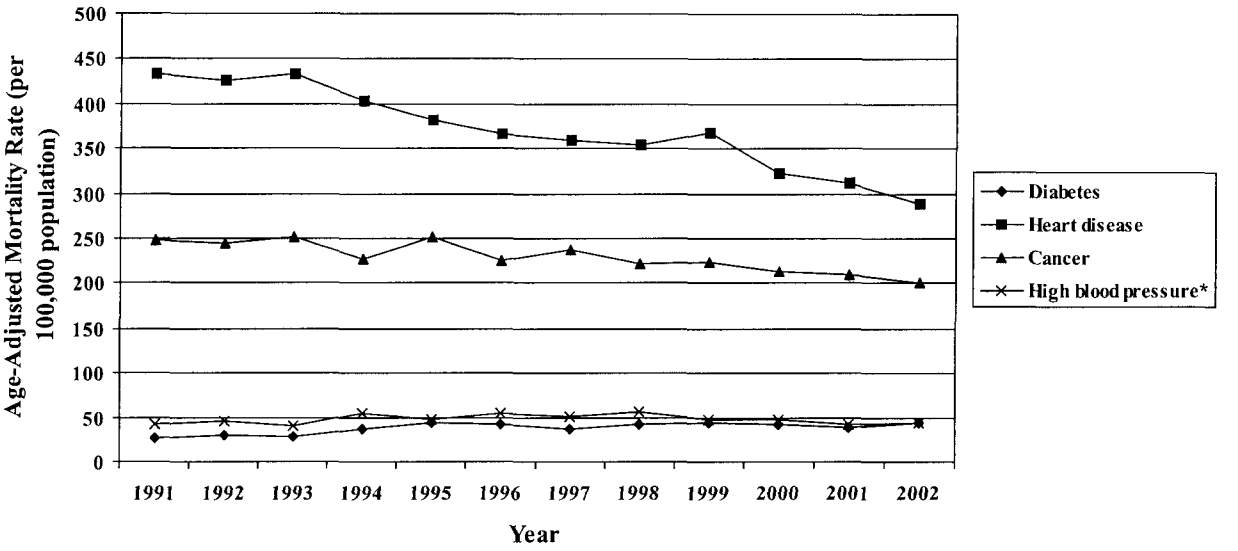
Table 3: Selected Health Outcomes for SPA 6, 2002/2003[a]

Health Outcome	SPA 6	Los Angeles County
Heart Disease mortality rate (age adjusted per 100,000 population)[b]	289.5	207.6
Diabetes mortality rate (age adjusted per 100,000 population)[b]	43.9	24.3
Cancer mortality rate (age adjusted per 100,000 population)[b]	200.3	154.6
Diabetes diagnoses among adults[c]	9.2%	7.2%
Hypertension diagnoses among adults[c]	25%	20%

a SPA 6 indicators are statistically different from indicators for Los Angeles County as a whole ($p<0.05$).
b Figures for Calendar Year 2002. SOURCE: Mortality: Linked Death Files (State and Local AVSS data). State data: Death Statmaster Files, California Department of Health Services, Office of Vital Records, Center for Health Statistics. Population: Population Estimation and Projection System (PEPS), Population Estimates 2002. Los Angeles County, Chief Administrative Office, Urban Research Division. Numbers and Rates compiled by Los Angeles County, Department of Health Services, Data Collection and Analysis Unit.
c SOURCE: LADHS, Office of Health Assessment and Epidemiology, Health Assessment Unit, 2002-2003 Los Angeles County Health Survey.

Figure 1 shows that, despite declining mortality rates, heart disease and cancer remain major killers in SPA 6. While mortality rates from high blood pressure and diabetes remain comparatively low, the diabetes mortality rate climbed from 25.6 per 100,000 population in 1991 to 43.9 per 100,000 population in 2002. Furthermore, nearly one in ten adults in SPA 6 has been diagnosed with diabetes, and one in four adults has been diagnosed with high blood pressure.

FIGURE 1: SELECTED SPA 6 MORTALITY RATES 1991-2002



Sources: Linked Mortality Files, LACDHS Data Collection and Analysis Unit, CY 1991-2002

Community resources

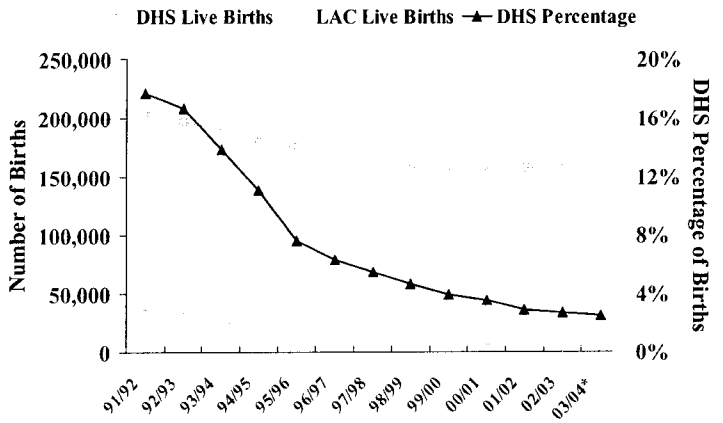
The health care needs of the community, and in particular those of the uninsured residents of SPA 6, must be evaluated in the larger context of the public and private healthcare resources in the area.

There is a range of institutions providing healthcare to the residents of SPA 6. There are five other hospitals within a five-mile radius of KDMC, and 31 additional private general acute care hospitals within a ten-mile radius. There are also several outpatient facilities in SPA 6, including two DHS Comprehensive Health Centers, one DHS Personal Health Center, two DHS Public Health Centers, and 14 Public-Private Partner facilities.

Over the last decade, the private hospitals have taken up much of the market in obstetrics and pediatrics in SPA 6. KDMC delivered less than half of one percent of the County's births in 2004: 622 out of a county total of 156,451 live births.[1] Figure 2 shows that there has been a steep decline in both number and percentage of births at DHS facilities since 1991, while Figure 3 shows that the decline affected each of the four DHS hospitals with Obstetrics services. Figures 4 and 5 show that there has been a steady decline in pediatric hospitalizations at DHS facilities, both in absolute numbers and in terms of market share. The most likely explanation for these trends is the range of programs that has brought insurance coverage to nearly all children and pregnant women in Los Angeles County. Simply put, women and children who have other options available are not seeking their health care at public hospitals.

[1] Automated Vital Statistics System, CY 2004.

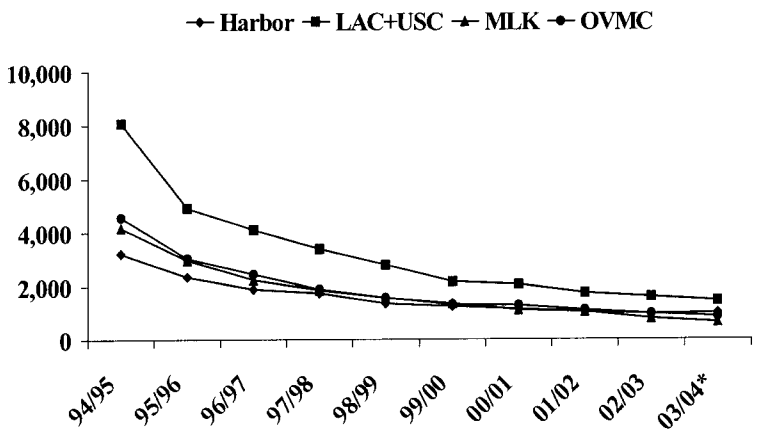
Figure 2: LAC Live Births, FY 91/92 to 03/04



Sources: Calif. DHS Birthmaster Files & AVSS Data
* CY 2004

LAC DHS Office of Planning, Data Quality and Analysis
6/17/05

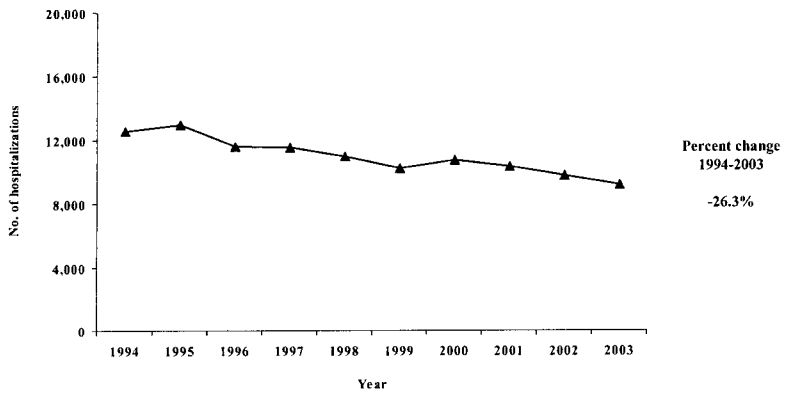
Figure 3: LAC DHS Hospital Births FY 94/95 to 03/04



Sources: Calif. DHS Birthmaster Files & AVSS Data
* CY 2004

LAC DHS Office of Planning, Data Quality and Analysis
6/17/05

Figure 4: Trends in Pediatric Hospitalizations* at DHS Facilities, Los Angeles County, 1994-2003**

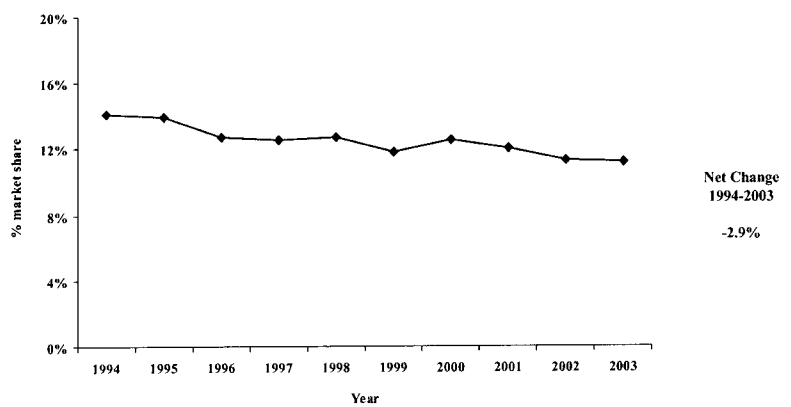


* Excludes newborns
** Includes hospitalizations at LAC+USC, Harbor-UCLA, MLK, and OVMC

Source: OSHPD Annual Hospital Discharge Data, CY1994-2003

LAC DHS Office of Planning, Data Quality and Analysis
6/17/05

Figure 5: DHS Market Share of Pediatric Hospitalizations* in Los Angeles County 1994-2003



*Market share is the percentage of pediatric hospitalizations in Los Angeles County (excluding newborns) which occurred at LADHS facilities.

Source: OSHPD Annual Hospital Discharge Data, CY1994-2003

LAC DHS Office of Planning,
Data Quality and Analysis
6/17/05

On the other hand, KDMC is a major provider of inpatient care for the uninsured residents of SPA 6 in many clinical areas including cancer, psychiatric disorders, diabetes, and cardiovascular disease. In 2003, KDMC provided seven percent of all hospitalizations for heart disease among SPA 6 residents, yet provided 28 percent of all the uninsured heart disease hospitalizations.[2] The facility also provided 13 percent of all hospitalizations for high blood pressure, which included 39 percent of the uninsured high blood pressure hospitalizations in the area. Similar patterns of caring for a higher percentage of the uninsured compared to the percentage of all SPA 6 inpatients were seen for diabetes, cancer, and chronic respiratory disease (see Table 4).

Table 4: Health Problems and Hospital Utilization in KDMC Catchment Area (SPA 6)[1]

Health Problem	Inpatient Discharges among SPA 6 Residents[2]					
	All Payer Sources			Uninsured		
	All Hospitals	KDMC	(%)	All Hospitals	KDMC	(%)
Heart Disease	11,033	745	7%	759	215	28%
Hypertension[3]	1,813	240	13%	137	54	39%
Diabetes	1,813	192	11%	295	79	27%
Asthma	3,340	380	11%	220	67	30%
Cancer	2,452	141	6%	221	62	28%
Depression	495	64	13%	173	39	23%
Psychosis	7,640	443	6%	1,128	257	23%
HIV/AIDS	659	73	11%	50	8	16%
Drug Overdose	515	76	15%	106	22	21%
Alcohol Dependence	124	2	2%	25	2	8%
Stroke	2,073	126	6%	140	23	16%
Chronic Liver Disease	1,055	119	11%	143	31	22%
Chronic Obstructive Pulmonary Disease	2,332	164	7%	107	27	25%
Pediatric Hospitalizations	38,900	2,028	5%	1,101	78	7%
Births[4]	21,150	593	3%	NA		

[1] KDMC Catchment Area (SPA 6) includes Compton, South, Southeast, and Southwest Health Districts.

[2] Source: OSHPD Hospital Annual Discharges, CY 2003. "All Hospitals" includes all public and private hospitals within Los Angeles County.

[3] Hypertension includes hypertensive renal disease.

[4] Source: Automated Vital Statistics System, FY 2002/2003.

[2] Office of Statewide Health Planning and Development (OSHPD) Annual Discharge Data, CY 2003.

DHS obtained input from community stakeholders (advocates, community leaders, labor, KDMC staff) and shared data on the health status of the population. There was general consensus that services for diabetes, cardiovascular ailments and cancer are important hospital priorities. It was also felt that the prevalence of chronic diseases such as diabetes and asthma should be addressed through greater focus on outpatient services, disease management and prevention, in order to improve quality of life for these patients and reduce costly ED visits and hospitalizations. A recurrent theme in these discussions was the desire for a KDMC that is attuned to the particular needs of its community and more integrated with other healthcare providers, public health, and community-based organizations serving the population. A service configuration with more focused inpatient services and a robust outpatient footprint would be an important step toward addressing these stakeholder recommendations.

Changing patterns of need

DHS must address longstanding areas of need in SPA 6, as well as respond to changes in the community's disease burden, access to healthcare services and utilization patterns. Cancer and heart disease remain by far the biggest killers in SPA 6, despite declining mortality rates; but the community also suffers increasingly from the triple-threat of diabetes, high cholesterol and hypertension. Demand for psychiatric services and emergency services, already high, promises to grow more critical as private hospitals increasingly get out of the business of indigent care in these areas. DHS must respond to the loss of OB and pediatric patients with commensurate reductions in those services. And DHS must be a central actor in the drive to manage chronic illnesses like diabetes and asthma at lower levels of care in order improve quality of life and reduce ED utilization.

Inpatient services are needed in several key areas. There is an ongoing need for adult medical/surgical beds and adult intensive care units, in part because of the prevalence of cancer, diabetes and cardiovascular diseases. Furthermore, there is a need to, at a minimum, maintain the volume of psychiatric services in the community.

Access to emergency services is critical given the high utilization of KDMC's ED. Before the closure of the Trauma Center, KDMC had the sixth highest ED volume in the County. ED access is high on the list of clinical needs in the area, and there are only two other hospitals with EDs within a five-mile radius of KDMC (St. Francis Medical Center and Community Hospital of Gardena). However, data analysis and strategic planning have allowed DHS to effectively fill the gap in the community's trauma system, such that the future of trauma care at KDMC can be considered in a much less pressurized and more informed manner while preserving ED services at KDMC.

There is a need for more outpatient care directed at prevention and early-stage treatment of chronic disease for the residents of SPA 6. Utilization of many of the aforementioned inpatient services could be reduced if residents had greater access to screening and treatment for diabetes, high cholesterol, and high blood pressure, as well as outpatient cancer treatment services. Furthermore, since the trend in pediatric hospitalizations at KDMC has declined 26 percent over the past ten years, a better use of resources to would be to strengthen pediatric outpatient care.

Patients needing prenatal and obstetrics care are nearly universally eligible for Medi-Cal or other coverage, even those who are undocumented. The sharp decline seen in births at KDMC, as at other County facilities, indicates that pregnant women are choosing to go to private facilities. The high rate of teen births and women without adequate prenatal care indicates that there is still a need, however, for family planning services and health education efforts to encourage women to get timely prenatal care.

ATTACHMENT C

ALTERNATIVE MODELS CONSIDERED FOR SERVICE DELIVERY IN SERVICE PLANNING AREA 6

At its May 10, 2005, meeting, the Board of Supervisors instructed the Chief Administrative Officer (CAO), in conjunction with the Director of Health Services (DHS), County Counsel and other appropriate departments, to develop a contingency plan for the option of contracting out services at KDMC and to contact potential qualified providers of hospital service who might be willing and able to perform as contractors. The Board also instructed County Counsel to report on the legal requirements, and CAO and DHS to report on employee relations implications, of such a plan. Further, the CAO and DHS were instructed jointly to open discussions with the University of California at Los Angeles (UCLA) and the University of Southern California (USC) Schools of Medicine to determine what role, if any, they could play in a contracted-out hospital.

As part of the plan development, DHS and CAO requested a report from the consulting firm of Shattuck Hammond Partners, LLC, on the issues facing the County in pursuing this option. Based on the consultant's report, contracting out the operations at KDMC is possible, contingent upon several factors, including the financial viability of such a change. That critical financial analysis cannot yet be completed, however, since the details of the State's Medi-Cal Redesign proposal, affecting the County's largest healthcare revenue stream, are still being finalized.

Further, it is important to delineate the services to be provided at the contracted-out hospital. DHS is currently completing its review of the healthcare delivery needs of Service Planning Area 6 and the role of KDMC in meeting those healthcare needs. This would include a determination of whether, under the contracting out plan, KDMC would remain a teaching hospital. At that point, DHS and CAO could proceed with discussions with the UCLA and USC Schools of Medicine on their potential role(s).

County Counsel has prepared a detailed analysis of the legal and regulatory issues that must be addressed, should the County determine to contract out the operation of the facility. While these issues must be factored into any discussions with a private provider, all of these issues can be addressed and would not preclude the contracting out the facility operations.

While initial discussions have taken place with representatives of interested parties, both the financial analysis and the restructuring of clinical programs must be completed before these discussions can proceed.

If the financial analysis indicates that contracting out can be viable and legal requirements have been addressed, the process of achieving a final contract with a provider for KDMC operations could take six to twelve months. If a decision is made to contract out the hospital operations, the process of reducing the County workforce, discussed further below, could take approximately six additional months to complete once a contractual agreement was reached. A transitional plan would be developed to continue operations at KDMC until the transfer is fully implemented.

Model #1: DHS-operated Multi-Service Ambulatory Care Center (MACC) only

This model has no licensed hospital on the current KDMC site. DHS would operate a full-service MACC on site. This facility would provide general and specialized physician care as well as ancillary services including laboratory and radiology. Some existing inpatient services would be absorbed by other DHS facilities while some inpatient beds would be purchased from private hospitals in the community. There would be no ED on site, although the MACC would include 24-hour Urgent Care services. Management functions for the MACC (including human resources, finance, etc.) would be merged with those at Harbor-UCLA Medical Center. A workforce reduction would take effect, with a large number of staff affected. Drew residents currently in training would need to be placed elsewhere, at least for inpatient rotations. This model relies on inpatient capacity in private sector and the loss of the ED and inpatient psychiatric services would have a significant impact on private sector facilities. Private sector EDs have been closing, and closure of KDMC's ED would further stress the system.

Human Resources impact and timelines

At this time the actual number of positions impacted in converting the hospital to a MACC has not been identified; however, it appears there would be a significant number of curtailments. While some staff impacted by these reductions could be reassigned to existing vacancies throughout DHS, workforce reduction would be necessary for displaced employees where internal department placement cannot be accommodated in accordance with Civil Service rules. Implementation of this model would take approximately 6 months.

Civil Service Rule 19 (Layoffs and Reemployment Lists) provides that the appointing power may lay off or reduce an employee for reasons of economy or lack of work, or when there are more employees than positions in any class within DHS. The Rule also describes the order of layoffs, the applicability of performance ratings and seniority in the layoff process, exceptions to the order of layoffs or reductions, voluntary reductions in lieu of layoffs, and the usage of reemployment lists.

Layoffs are by department. However, CSR 19.02 (2) allows DHS, with Director of Personnel approval, to lay off by a unit other than department (i.e., facility or hospital) for employees in non-represented supervisory and management classes only.

Once a determination is made by DHS that a workforce reduction is necessary, there are several requirements that must be met before the layoff process can begin. DHS would begin by notifying DHR, the CAO, and the affected union(s), while simultaneously posting the Seniority List. The Board of Supervisors is notified (at least 30 days in advance) and DHS' Workforce Reduction Plan is submitted to DHR. Upon approval, the Workforce Reduction Plan is returned to DHS and copies are forwarded to the Office of Affirmative Action Compliance and the CAO (Budget and Employee Relations). The CAO Employee Relations staff coordinates meetings with the unions while DHS finalizes and distributes letters to employees affected by layoffs, reductions or transfers (notice given at least 10 days prior to effective date). DHS and DHR continue mitigation efforts up until the time that the Workforce Reduction Plan is implemented and the employees are impacted. Grievances and complaints are processed while reemployment lists are utilized by all departments and monitored by DHR.
Mitigation efforts are a crucial part of the Workforce Reduction process. These efforts are required by the applicable Memorandum of Understandings (MOUs) and policies set forth by DHR and the Board of Supervisors, and are designed to lessen the number of impacted employees. Mitigation

efforts can begin as early as the pre-planning stage when the affected department can find internal, alternative placement for employees through attrition or existing vacancies. Other types of mitigation include placing employees in vacant positions in other County departments, the discontinuance of departmental personnel services contracts and/or non-County contracted temporary personnel who perform functions comparable to County positions subject to demotion or layoff, the usage of Enhanced Voluntary Time-off, and voluntary reductions in lieu of layoffs. Retraining and outplacement services are also utilized in the mitigation process.

Academic Affiliation

Implementation of this model will have a major impact on Drew University, and will engender serious debate about the future of its resident training programs. The County could offer an academic footprint as part of this model; however the role of the County in providing residency training is minimized. It would not make sense for the County to continue to support full residencies at the facility. Drew or another academic affiliate would need to provide the full range of training requirements, including inpatient care at other facilities. Drew University would need to decide whether to continue residency programs using rotations to other hospitals, negotiate a comprehensive training contract with a new hospital, or discontinue the programs. If any programs are discontinued, Drew should notify ACGME and the National Resident Match Program (NRMP) by January 31, 2006 to ensure that residency applicants will not be matched to KDMC for the academic year 2006/2007.

Pros and Cons of this Model

Advantages of this model include: Most of the quality and safety issues related to current staff and the operation of inpatient and ED services will become moot.

Disadvantages include: Closure of the ED will have a negative impact on patient access and on the private sector EDs in the area; closure timeline will take up to one year, during which time recruitment will be extraordinarily difficult; workforce reduction will impact up to 2,400 employees and will affect other DHS hospitals; major impact on the viability of Drew, and residents in the middle of training programs would need to be placed elsewhere; private sector capacity for inpatient medical/surgical beds in the area is limited, so some patients may need to travel farther (to other DHS facilities) for care; depending on how Medi-Cal Redesign is implanted, possible loss of revenue to County due to a reduction in DSH funds; and County may still retain responsibility for providing certain inpatient services to Section 17000 patients.

Model #2: Contractor-operated hospital with DHS-operated MACC

If a qualified, interested contractor can be identified, hospital services could be contracted out. Depending on the legal and financial considerations, the hospital license might be retained by DHS, or obtained directly by the contractor. Under this model, DHS would likely establish a MACC on site and would continue to be the main provider of ambulatory care. Management functions for the MACC (including Human Resources, Finance, etc.) would be merged with those at Harbor-UCLA Medical Center. This model has the potential to reinvigorate the hospital and the community by bringing the resources of a private hospital system into the community, including new management, more flexibility in human resources, marketing services, et cetera.

Human Resources impact and timelines

If the contractor employs its own workforce, this model will result in a major workforce reduction. Implementation of this model would result in the elimination of a substantial number of the 2,400 currently budgeted positions. As with the other models, staff could be reassigned to existing vacancies throughout DHS in accordance with Civil Service rules. Due to the large number of positions being eliminated, it would likely result in a substantial number of layoffs and staff being reduced to lower level positions. If DHS operates a MACC on-site, however, some staff would remain. It is likely that the new hospital operator would offer some current KDMC employees employment, but they would no longer be County employees. Considering the large number of curtailments, implementation of this model would take approximately six months.

Academic Affiliation

As with the previous model, implementation of this model would have a major impact on Drew. Drew would need to decide whether to continue residency programs using rotations to other hospitals, negotiate a training contract with the new hospital operator, or discontinue the programs. If any programs are discontinued, Drew should notify ACGME and the National Resident Match Program (NRMP) by January 31, 2006 to ensure that residency applicants will not be matched to KDMC for the academic year 2006/2007.

Pros and Cons of this Model

Advantages of this model include: A full-service hospital is maintained on the current site; new management with fresh perspective and additional resources; increased recruitment opportunities due to new ownership/management and salary structure; flexibility in staffing if Civil Service rules no longer apply; quality and safety issues related to current staff will be resolved; apolitical governance (if license is transferred); and a DHS-operated MACC could provide outpatient services to supplement those not provided by the hospital.

Disadvantages include: Negotiation period of six to twelve months (per Shattuck Hammond report), followed by implementation phase of six months or more, during which time recruitment will likely be extremely difficult; workforce reduction will impact up to 2,400 employees and will affect other DHS hospitals; major impact on the viability of Drew, and residents in the middle of training programs would need to be placed elsewhere; possible disruption of services and temporary closure of hospital during transition from DHS to private entity; possible loss of revenue to County due to loss of DSH funds; County will still retain some financial responsibility, due to Section 17000 obligations and other legal or negotiated requirements; and Proposition A considerations.

ATTACHMENT D

KDMC CLINICAL FOOTPRINT: CURRENT AND MODEL 3

WORKLOAD BY MEDICAL SERVICE

Inpatient Hospital Service Areas	**FY 04/05* ADC**	**Proposed FY 06/07 ADC**
Medical/Surgical Acute	93.0	100.0
Gynecology	3.7	
Obstetrics	8.3	0.0
Intensive Care/Critical Care	20.1	20.0
Psychiatric Acute	21.3	34.0
Pediatric Acute	10.8	0.0
Intensive Care - Pediatrics	3.0	0.0
Intensive Care - Neonatal	14.0	0.0
Total Inpatient Average Daily Census (ADC)	174.2	154.0

Outpatient Hospital Service Areas	**FY 04/05* Visits**	**Proposed FY 06/07 Visits**
Emergency Room	31,725	31,725
Psychiatric ER	4,237	4,237
Medical Outpatient	35,193	40,000
Pediatrics	18,912	22,000
Eye	12,472	12,472
Surgical Outpatient	12,276	12,276
Oral Maxillofacial	8,792	8,792
Orthopedics	7,889	7,889
Special Services (OT, PT)	7,743	7,743
Ear, Nose and Throat	7,653	7,653
Gynecology	7,180	7,180
OB/Prenatal	5,641	0
Total Outpatient Visits	159,713	161,968

*Full year estimate as of March, 2005

Source: March 2005 IR Statmaster

ACTION PLAN AND PROPOSED TIMELINE FOR IMPLEMENTATION OF MODEL 3

THIS ACTION PLAN ASSUMES A 6/30/06 COMPLETION DATE

Action Step	Responsible Party	Due Date	Notes
Consult with union	CAO	ASAP	
Finalize revised clinical footprint, incl. number of beds and outpatient visits	DHS Clinical Affairs	8-16-05	
Determine DHS and private sector capacity for eliminated services	DHS Clinical Affairs	8-16-05	
Finalize staffing changes needed for revised clinical footprint	DHS Clinical Affairs, HR	9-15-05	
Review space and capital equipment needs/changes	KDMC CEO, COO	9-15-05	
Notify Drew of intent to discontinue programs	DHS Clinical Affairs	9-15-05	
Complete plan for referral of OB patients	KDMC Medical Director, DHS Clinical Affairs	9-15-05	
Complete plan for referral of pediatric patients needing inpatient care	KDMC Medical Director, DHS Clinical Affairs	9-15-05	
Finance review & budget for 06/07	DHs Finance	9-19-05	Required for preparation of Beilenson notices
Post Beilenson notices	DHS COO	10-2-05	14 days prior to Hearing
Complete outpatient expansion plans (for comprehensive cancer, diabetes/high cholesterol/high blood pressure. and expanded Pediatrics program)	KDMC Medical Director, CEO	10-15-05	
Conduct Beilenson Hearing	Board of Supervisors	10-17-05	
Release RFP for contracted doctors (ED, Radiology, ICU, Anesthesiology)	DHS Contracts & Grants	10-31-05	
Select vendor and negotiate contracts for doctors	KDMC CEO, Contracts & Grants	12-30-05	
Determine impact of changes on CHP enrollees	Office of Managed Care	12-30-05	
Assess which contracts must be terminated or amended (e.g., equipment, supplies)	KDMC CEO, Contracts & Grants	12-30-05	
Notify ACGME, NRMP (National Registry Match Program), and residents	Drew University	1-31-06	

Revise staffing model to plan for cascade	DHS Clinical Affairs, DHR, CAO	2-1-06	
CHP member notification of changes	Office of Managed Care	4-30-06	
Complete Proposition A analysis for contracted doctors	Auditor-Controller	4-30-06	Begins after potential vendor is selected
Amend, re-negotiate or terminate contracts, as needed	KDMC CEO, Contracts & Grants	4-30-06	
Complete placement plan for OB, Peds residents	Drew University, DHS Clinical Affairs	4-30-06	
Run cascade for revised staffing model and new clinical footprint	DHS HR	6-1-06	
Notify affected staff, facilities	DHS HR	6-15-06	
Transfer of staff	DHS HR	6-30-06	
Contracted physician services fully implemented	KDMC Medical Director	6-30-06	
Implementation of revised clinical footprint	KDMC CEO, Medical Director	7-1-06	